(Ms. JACKSON-LEE addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

COMMUNICATION FROM THE CHAIRMAN OF THE COMMITTEE ON THE BUDGET REGARDING REVISIONS TO THE ALLOCATION FOR THE HOUSE COMMITTEE ON APPROPRIATIONS PURSUANT TO SECTION 2 OF HOUSE BUDGET RESOLUTION 477

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. KASICH) is recognized for 5 minutes.

Mr. KASICH. Mr. Speaker, pursuant to Sec. 314 of the Congressional Budget Act, I hereby submit for printing in the Congressional Record revisions to the allocation for the House Committee on Appropriations pursuant to section 2 of House Resolution 477 to reflect $355,000,000 in additional new budget authority and $323,000,000 in additional outlays for continuing disability reviews. In addition, revisions to the allocation for the House Committee on Appropriations should reflect $20,000,000 in additional new budget authority and $12,000,000 in additional outlays for adoption incentive payments. This will increase the allocation to the Appropriations Committee to $532,954,000 in budget authority and $563,221,000,000 in outlays for fiscal year 1999.

As reported by the House Committee on Appropriations, H.R. 4274, a bill making appropriations for the Departments of Labor, Health and Human Services, Education and Related Agencies for Fiscal Year 1999 includes $355,000,000 in budget authority and $323,000,000 in outlays for continuing disability reviews. The bill also includes $20,000,000 in new budget authority and $12,000,000 in outlays for adoption incentive payments.

These adjustments shall apply while the legislation is under consideration and shall take effect upon final enactment of the legislation.

Questions may be directed to Art Sauer or Jim Bates at x6=7270.

RESULTS OF GOVERNMENT MEDDLING IN HEALTH CARE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Tennessee (Mr. DUNCAN) is recognized for 5 minutes.

Mr. DUNCAN. Mr. Speaker, we will soon pass some type of patients rights bill, and we need to do this. But it is really sad that it is necessary to do this.

Prior to the mid-1960s, medical care in this country was of high quality and very low cost. The cost was low and flat for many, many years. Then the Federal Government got into medical care in a big way and costs exploded and we got things like HMOs.

The government took what was then a very minor problem for a very few people and we turned it into a very major problem for everyone. Almost everyone, with the exception of Bill Gates and Warren Buffett, could be wiped out by some type of major medical catastrophe.

All the government has done is to do what it has always done best, make a very few filthy rich at the great expense to the very many.

Look at nursing homes. Those few who were lucky enough to get into the nursing home business, those favored enough to get nursing home licenses, have gotten rich because of government restrictions on the number of nursing homes and the overregulation that always drives small operators out.

The result: The cost of nursing home care is probably double or triple what it would be if the government had stayed out and had let the free market operate.

Medical care is the only thing we are paying for through a third-party payer system. If we bought cars this way, a Yugo probably would have cost $300,000. When someone else is footing the bill, cost no longer matters and everyone wants the most expensive product or treatment available. Thank goodness most of us are not paying for food through a third-party paying system.

A few years ago, I asked a hospital administrator in my district what would happen if the government got totally out of medical care. He told me that prices would go down 50 percent within days, and probably another 50 percent over the next 6 months. So, they would very quickly be 25 percent or less of what they are now.

Obviously, though, we cannot dismantle this overpriced and unfair system that we have now. Too many doctors, hospitals, and medical businesses would scream to high heaven if we did. So what should we do? Realistically, all we can do is reform around the edges and hope the system does not become even worse and even more expensive.

Medical savings accounts or medical vouchers would help some, because they would give people some incentive to shop around. But what I really want to do tonight is read a portion of a column from yesterday's Washington Post by James K. Glassman, who is consistently one of the very best commentators on the political scene today.

Mr. Glassman wrote, ''Employers today foot most of the bills for health insurance, so they determine the policies their workers get. As costs soared in the 1980s, employers turned to HMOs and managed care, restricting their workers' choices.

''Health insurance policies aren't really 'insurance'; their purpose is to prepay medical costs that are predictable or inexpensive, like checkups and flu visits. This is like auto insurance paying for an oil change. But since Uncle Sam is footing a big part of the bill, it makes sense for health 'insurance' to be all-inclusive, with low deductibles.

''Employees have little incentive to self-ration the care they get. Imagine a tax subsidy for food insurance, provided by your employer. You would naturally buy steak instead of chicken. Soon, however, the insurer would respond by limiting your steak-buying to once a month, or by forcing you to buy all your food at a specific grocery chain with no steak in its coolers. Given this restricted choice, you would probably rush to a politician to complain.

''The solution for health insurance is to end the tax subsidies, which currently cost the Treasury more than $100 billion a year. Instead, give that money back to individual Americans either through tax credits or rate reductions that would leave more money in their pockets. We should probably require everyone to have some type of catastrophic insurance (say, for expenses over $2,500), and the government should foot the bill for the poor through insurance vouchers (like food stamps).

''Then we would have a real market with far less paperwork and with people buying the sort of insurance they really want . . . not just what their employers force them to take. The final insult of the tax exclusion is that it mainly benefits those who need it least. The Lewin Group found that 64 percent of subsidies in 1996 went to families making $50,000 a year or more, while 11 percent went to those making less than $30,000.

''Instead of pandering to fear,'' Mr. Glassman wrote, ''politicians should level with voters. End the tax exclusion and let people buy their own health policies. Insurance companies, which benefit from billions in subsidies, might howl, but choices would broaden, costs would fall, and paperwork would be drastically reduced and the destructive cycle of excess, cutbacks in care, and political intervention would end.''

MANAGED CARE REFORM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentleman from New Jersey (Mr. PALLONE) is recognized for half the time until midnight as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I am pleased tonight to be joined by two of my colleagues to talk about managed care reform, the gentleman from Texas (Mr. TURNER) and the gentleman from Pennsylvania (Mr. KLINK).

Before I yield to them, I wanted to talk briefly about the Republicans' managed care reform bill, which to be accurate I like to call the Insurance Industry Protection Act. The reason I bring this up is because it has been noticed to be debated and, theoretically, I suppose approved or disapproved on the floor this Friday.

This Republican version of managed care reform is in my opinion easily one of the worst pieces of legislation the Republicans have put forward since they took control of Congress in 1994.

For weeks prior to the introduction of the Republicans' Insurance Industry Protection Act, supporters of the Democrat's alternative, the Patients'

Bill of Rights, were speaking out about what we knew was coming.

What we expected they would do is to introduce a bill that was greatly watered down as a sort of cosmetic fix with regard to managed care reform. We expected the Republican leadership, who really are not interested in passing a managed care reform bill, would come out with a bill that would purport to provide patient protections, but really would not.

The managed care issue, Mr. Speaker, is too explosive for the Republicans to ignore, so they have to at least create the impression that they are trying to rectify the weaknesses in the current system that are leading to the abuses we hear about on a daily basis.

Let me say, we are truly hearing about these abuses daily. One need only turn on the TV, as I did tonight on the 6 o'clock news or pick up the newspaper, and see what I am talking about. In any event, just as we expected, before Congress adjourned for the July 4th recess, the Republicans released a set of principles which they said would all be incorporated into their bill.

Mr. Speaker, these principles confirmed what Democrats expected. The Republican bill was going to be written so as not to interrupt the flow of support streaming into the Republican Party from the insurance industry.

Last Friday, we finally got to see the language, and I think the American people need to know that the Republican Party went far beyond a cosmetic fix. They have introduced a bill that is far, far worse in my opinion than the existing law. Finding themselves caught between the insurance industry and the American people, the Republicans chose the insurance industry.

Now they are gearing up to stuff this bill down the throats of the American people without giving them a chance to look at it. The Republican bill is scheduled, as I said, to be on the floor on Friday.

In order to ensure the American people know as little about it as possible before everyone in the House is asked to vote on it, the leadership has bypassed the committee process. Not one of the three committees that has jurisdiction over this bill has had or will have a hearing on the Republican bill. And I would stress again that the language was only available last Friday.

Because the Republican leadership refused to have hearings on its own bill, this week the Democratic Health Care Task Force held two hearings on this legislation. That was yesterday and today. At these hearings we heard testimony from administration officials, including the Secretary of Health and Human Services, Donna Shalala, and patients who have been abused by HMOs, doctors, and others. These hearings generated some truly disturbing and chilling revelations, I think, about the Republican bill.

Mr. Speaker, I am not going to go into all of those now, because I think we can bring them out this evening as I yield to my colleagues who are here to join me and talk about some of the protections that are missing from the Republican plan, but included in the Democrat's Patients' Bill of Rights.

Also, at some point I would like to talk about the issue of enforcement and how effectively the Republican bill has no enforcement. But at this time, I yield to the gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Speaker, I thank the gentleman from New Jersey (Mr. PALLONE) for yielding. It is an important evening, though it be a late hour here in this hall. We will be, by all reports, considering managed care legislation on Friday. A very important day for the House, a very important day for the American people. A very important day for the future of health care in the United States.

This is an issue that all of us, I think, take very personally. I, just a few weeks ago, took my father to the hospital because he was having some symptoms of dizziness and the doctor suspected it might be an early sign of stroke. We went immediately out to our hospital and he was given a CAT scan and, fortunately, it was determined that his dizziness was not a result of signs of early stroke.

But I cannot help but think about what it would have been like if my father had been enrolled in a managed care plan, rather than being covered under Medicare. When we found out that he perhaps had an early sign of stroke, we would have been faced with calling our doctor and our doctor then having to call the HMO supervisor or clerk and determining first whether or not that procedure would have been authorized.

It is in those kinds of delays that have been caused so many times in recent reports by many patients who have had unfortunate dealing with their HMO, it is those kinds of delays that make the difference in life or death.

Mr. Speaker, I am very pleased that we have a bill as Democrats authored by the gentleman from Michigan (Mr. DINGELL), a man who has served many years in this Congress, serving as chairman of the Committee on Commerce, and now as ranking member of the Committee on Commerce, a man who has been a leader in this Congress in providing a responsible managed care legislation.

I had the opportunity, when I was in the State Senate in Texas in 1995, to pass one of the first managed care bills passed anywhere in these United States. Interestingly enough, when we passed it in Texas, it had bipartisan support. In fact, the bill passed both the House and the Senate with relatively little opposition. It was a good strong bill.

In Texas today, we have protection in place and, interestingly enough, we have had no increase in health care premiums as a result of the patient protection legislation that we passed in 1997, which was the year after I initially passed the bill followed by a veto of our governor and then repassage of the bill in 1995.

So we have a good law in Texas. Now, I was surprised to learn just a few years ago that the legislation that we were working on and passed in Texas in 1995, and finally passed in Texas in 1997, does not apply to about half of the people who are enrolled in managed care in the State of Texas. That is because the courts have ruled that the ERISA law, a Federal law, preempts the State legislation that was adopted overwhelmingly by our State legislature.

The reason we are considering this legislation in Congress is because the ERISA law has been interpreted by the courts to exempt all those enrolled in self-insured health care plans that are covered by ERISA, to exempt them from all the patient protections that have been passed in most of our States across our country.

So we here in Congress feel very strongly on the Democratic side that it is wrong to have two classes of patients out there in Texas and the many other States that have passed patient protections. One group of patients who have the protections that were provided by their State legislatures, and the other group of patients who do not have those protections because a Federal court has ruled that their self-insured plan covered by ERISA is not covered by the protections that their legislature has put into the law.

That is why we are here. The Democrats have come up with a bill that provides an answer to that problem. Our bill makes it clear that not only do we provide a clear base of protection in the law for everyone enrolled in managed care, but we provide each State the right to control all of the legal liabilities that relate to providing health care under those managed care plans.

Our bill is a plan that respects States' rights and it is a plan that protects patients uniformly, irrespective of what kind of health care plan that they are enrolled in.

So I think that we have a good bill, one that will stand the test of time, and contrary to the Republican plan will leave two classes of patients out there in this country, one covered by one set of rules that the Republicans want to place on ERISA covered plans and the other patients covered by the variety of State laws that have been passed across this country, but we as Democrats have a bill that will provide every patient the same protection who are enrolled in managed care plans in this country.

Mr. PALLONE. Well, I just wanted to say that my colleague from Texas has brought up a number of really important points here. Number one, the whole issue of costs, we have been criticized, Democrats have been criticized, for their patient protection bill

by the allegations by the insurance industry that it is going to cost a lot more money.

The gentleman points out that in Texas, there has actually been no premium increase. We had a report from the Congressional Budget Office that just came out a couple of weeks ago on our Democrat bill that said that even if everything passed and our bill was law, at the most, individuals would pay only about two dollars more per month for the patient protections that are so important to the American people.

The other thing the gentleman pointed out is that we have, in effect, now, these two regimes, if you will, for people who are in ERISA and they are working for an employer that has a self-insured plan, which now preempts, the Federal law preempts it, and those people are not coming under ERISA.

One of the things that is important is some of the proposals put forward by the Republicans, particularly the Senate proposal, actually does not even provide the patient protections if you are not under ERISA. So for those people who live in States other than Texas, that do not have the patient protections, they are not even going to get the patient protections if they are not in an ERISA self-insured type program.

The other thing I wanted to say that the gentleman really brought out, and I think it is very important, too, is this whole issue of enforcement. We have been criticized by some of the opponents of managed care reform and they have said, well, the only difference or the only thing the Democrats want to do is they want to eliminate the ERISA exemption on the ability to bring suit, because under ERISA you cannot sue effectively for damages or to really recover the damages or the fact that you were not able to work or that you basically had a number of losses, you cannot bring a suit if you are under an ERISA plan because of the exemption from liability.

What I wanted to point out is that if we do not repeal that ERISA exemption on liability, there is not going to be any effective enforcement of these patient protections.

One of the criticisms I have is that under the Republican proposal in the House, basically not only do they not permit you to sue, they do not repeal the ERISA exemption on the ability to sue, but they also say that for individuals who have to buy the insurance in the individual market and not through a group plan, that they do not even have access to an appeal procedure where if they have been denied proper care, they do not even have a way of taking the appeal of that decision under the Republican proposal.

So the Republican proposal in the House, on the one hand, excludes a lot of people from any kind of appeal if they have been denied coverage. It does not allow a lot of people to bring suit, if they are covered under ERISA, and essentially there is no enforcement. So there are tremendous loopholes in this Republican plan that we need to address and it is one of the reasons why we have been so critical of it.

At this point, I yield to the gentleman from Pennsylvania (Mr. KLINK), who is on the Committee on Commerce and has been really outspoken in bringing his concerns about managed care home to his constituents. I know the gentleman has had a lot of forums and he has heard a lot of horror stories over the last 6 months.

Mr. KLINK. The gentleman from New Jersey is right. I want to thank the gentleman from New Jersey for his leadership on this issue. He has been here relentlessly, tirelessly, night after night, day after day, as he has been in the Democratic hearings, as he has been in talking with Members on both sides of the aisle trying to educate Members on this issue, and I think you are to be lauded, regardless of what comes out of the effort by either party. The gentleman has worked very hard on this issue.

Before I get to my comments, I think I want to get to what the gentleman from New Jersey and the gentleman from Texas (Mr. TURNER) were talking about. We sometimes start talking in alphabet soup terms in Washington, D.C. We talk in acronyms because it is the way the bureaucracy operates. We do not have time to say these long names and so we shorten it to the acronym, and ERISA is a very confusing acronym because it is a very complex law.

Anyone who knew this law inside and out would make hundreds upon hundreds of thousands, if not millions, of dollars each year consulting with companies. It is the Employee Retirement Income Security Act, and that is why we call it ERISA. It deals, as the gentleman from New Jersey and the gentleman from Texas have stated, with multistate employers, usually self-insured, companies like General Motors, FORD, Chrysler, IBM, Westinghouse Electric, Pennsylvania Plateglass. All of these large multistate employers, because they are located in more than one State, do not come under a State insurance commissioner. They come under the Federal Government.

In coming under the Federal Government, the judges, as was stated by my two colleagues, have determined that because of the ERISA law, because of this long named law, you cannot sue those insurance companies when they make a medical decision. If they deny you access to a hospital and you drop over dead, you could only retrieve from them the cost of the time you would have been in the hospital, or if they discharge you from the hospital early and you die or you lose a limb, you cannot get the cost of the damages for the loss of life or for the limb that you have lost. You can only get the 2 days that they denied you to be in the hospital. How ridiculous that is.

The Democratic plan says, that is ridiculous. If you are going to make medical decisions, then you should be liable when those decisions are wrong. You should not be the callous kind of person that says, you have no choice. We are making the decision. I am looking at a set of figures here. You do not go to the hospital, unless you are willing to pay the piper when that decision is wrong.

The Republican plan does not fix that. It does not make people who are making medical decisions, even though they may not be medically trained, because they work for insurance companies, it does not make those insurance company personnel responsible. Then, what the Republican plan further does, which the gentleman from New Jersey, I thought, explained very well, it only relates to those employers who come under ERISA plans, those multistate employers.

If you work for a small company, if you are self-employed, if your employer is within one State where you come under that State insurance commissioner in all 50 states, you get no protection from the GOP plan at all. This plan is left wanting on both ends, and that is the difficulty.

My problem with this is that this whole managed care debate is life and death. It is a life and death decision.

I can remember back in 1993 and 1994, my friend, the gentleman from New Jersey, was here with me and we were trying to work on tackling this issue. I was not a proponent at that time of the Clinton plan, although I thought we needed to do something. I was at that time for more of a, let us try this and then we will do this. I did not like the whole omnibus idea, but what happened is something that is happening now and we have to learn from history, and that is the insurance companies took to the airwaves of this nation, spending tens of millions of dollars, saying, you do not want the Federal Government to have control of your insurance and, lo and behold, the people of America listened to all of those Harry and Louise ads and we said, I guess we do not want the Federal Government.

Why would we want the government involved in our health care, not stopping to think that Medicare, which seems to work pretty well, which is run by the government, is controlled by the same government.

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But nobody put two and two together. Very few people did. And so the insurance companies won, the Clinton administration lost, and life went on, except life did not exactly go on. Because the insurance companies now have control over the health care delivery system of this Nation. It is not big government, it is big business. And decisions are being made not for health reasons but for reasons of increasing the profits of those people who invest in or who manage those insurance companies. That is how the decisions are being made today.

I began early last year in a small town called Slickville, Pennsylvania. Because I could not talk my Republican colleagues into holding hearings on this matter, we went to the tiny town of Slickville after hearing horror stories from doctors who could not treat their patients anymore because they could not be included in the HMO, after hearing from patients who no longer could go to their doctors because their doctors were not in the HMO and they had no choice, by the way, because their employer took the HMO. It was not like they had a choice to go out because they could not afford to go outside the employer plan. But now they could not go to their own doctors and they could not go to the hospital of their choice and they could not go to the pharmacist of their choice, they could not get the drugs that their doctor was recommending for them. They had all kinds of problems. We began over 60 hours of hearings. We heard horror stories which told me one thing. The people of this country were aware of what happened since the failure of the Clinton plan until now, they knew there was a problem, but inside the Beltway, the people running the House of Representatives here did not understand it, and I think to this day as they try to ram a bill that is horrible, without hearings, down the throats of this Congress and the American people, they still do not understand. They still do not get it. I will tell you, people know they are getting a raw deal. They know what is happening when the insurance companies force them to go through a series of hoops with the hope that somewhere along the line they will just give up and not fight anymore for the treatment that they should get. They know they are getting a raw deal when they cannot even get good information about what it is their insurance covers in the first place. And when their doctor has only two minutes to see them because they have to see so many more patients under managed care. Or when they cannot go to see a specialist that they may have been going to for years without having to go across town or to a different town to get a referral from a primary care physician. And they know they are getting a raw deal when they get these ridiculous bills from their insurer because they fell down unconscious and they failed to call the HMO for authorization when the ambulance then picked them up and took them to the nearest emergency room. Or they know they are getting a raw deal when they get kicked out of a hospital the day after major surgery even though the doctor says you need to stay in this hospital. And they know they are getting a raw deal, they know that something really bad is happening because care was denied and they discovered the health insurers are about the only type of business in this country that cannot be sued for pain or suffering when they make a decision.

The Democratic Patients' Bill of Rights has answers for all these problems, but regrettably the Gingrich plan does not. It is that simple. One of the women, and really this is a horror story that we had, Mrs. Bloise from New Castle, Pennsylvania, her daughter came to see us in New Castle. It turns out her mother was admitted to a great hospital, the Cleveland Clinic, on December 13 of last year for surgery on her esophagus. By all accounts the surgery was very successful. But it was major surgery and it required a degree of postoperative attention.

What happened is really beyond my comprehension I would say, Mr. Speaker. Even though she wanted to stay in the hospital after the surgery, and her family wanted her to stay in the hospital, and her doctor wanted her to stay in the hospital, Mrs. Bloise was discharged two days after major surgery on her esophagus over the objection of her family, her doctor and told she would have to come back two days later. But she was too sick to travel hours away from the Cleveland Clinic to New Castle, Pennsylvania. She was in no condition to travel. A day and a half after traumatic surgery, she was discharged and told she would have no choice but to stay at a hotel room across the street from the Cleveland Clinic and wait for her appointment two days later. Well, they did not have to worry about paying any more of Mrs. Bloise's hospital bills because she died in that hotel across the street from the Cleveland Clinic.

Now, our dear friends in the insurance companies, they hear these stories, they say, ''Well, this is just anecdotal.'' When you get this many anecdotal stories in 60 hours of hearing in my district alone, something is wrong in this country with our health care delivery system and people are dying. And we are not just saying this because it sounds good, we are saying it because it is true and they are our constituents, they are our family members. Not one person that any of us, Republican, Democrat, Independent, Communist, Socialist, Green Party, not one person that we know, not one person that we talk to does not know someone who has not had a raw deal from the insurance companies. They now control health care. The Democrats want to change that. The Republicans, now wedded to the insurance companies, want to keep it business as usual. That is what they are going to try to do this Friday and it is a shame.

How in the world, and I am a pro-life Democrat, but I am going to tell you something, I do not know how my friends on the pro-life side on the Republicans can say they are pro-life when they want this kind of loss of life, this kind of pain and suffering to continue day in and day out and they do not want to stand up to the insurance companies and do something about it. You cannot be pro-life until the child is born and then from that point on through their life when they are fighting to see doctors, when they are fighting to get medical care to save that life you turn your back on them. That is exactly what is happening.

Mr. PALLONE. I just want to thank the gentleman again for his contribution here tonight, because I know how strongly he feels about this. He has all these cases. He has really spent the time in his district giving forums and opportunities, if you will, for individuals to come forward and talk about these abuses. We know how many there are.

I just wanted to say briefly and then I will yield to the gentlewoman from Michigan. One of the major problems with the Republican bill is that when I talk to constituents and when I get feedback from different individuals, what they really want, most importantly, is the return of medical decision-making to patients and health care professionals, doctors, and not have medical decisions made by the insurance companies. The worst part I think of the Republican bill, the House bill and the Senate bill, is that it allows the insurance company, the HMO, to define medical necessity, so that we as Democrats have said that what we want to do is switch this whole phenomena so that the decision about whether or not you are going to be able to stay in the hospital a few more days or whether you have a certain medical procedure is made by the patient and the doctor.

Well, if you leave it as the Republican bill does, if you leave the definition of what is medically necessary to the HMO, you do not have any patient protections. This is what I have been trying to say the last few days when this Republican bill was finally revealed last Friday, that it actually does not move us forward at all in terms of patient protections. This is one of the major reasons, because the definition of what is medically necessary is still going to be left up to the HMO.

I just wanted to mention a few things briefly, because I do not know that we have specifically talked about some of the differences in terms of the actual patient protections. One is what I have mentioned, the protection of the doctor-patient relationship. It is still denied essentially by the Republican plan. The other is access to specialists. The Democratic plan lets you go to a specialist outside the network if there is not one available within the HMO network. The Republican bill does not allow that. The Republican bill does not do anything in terms of coverage of mastectomies and requirement of coverage for reconstructive surgery. In other words, in our bill, we have a prohibition on the drive-through mastectomies and we require coverage for reconstructive surgery after a mastectomy. This is a very important provision that we have talked about for some time that is not in the Republican bill.

Point of service. A big issue for a lot of Americans is the ability to go outside of the HMO network and see a doctor outside the network even if they

have to pay a little more if they want to do that. What the Democratic bill says is if your employer only offers you an HMO, a closed panel HMO, for only doctors or hospitals within the network, he also has to offer you initially the option of going outside the network if you are going to pay a little more. Well, in the Republican bill, they have so many loopholes in their point of service option that it might as well not exist. They say that there is an exemption for these new health insurance pools, there is an exemption if the employer does not want to contract with a plan to provide the point of service. They might as well not have anything.

□ 2320

I mean, they have so many loopholes it is incredible. So there is no point of service. There is no option, really, to go outside of the plan for a doctor or a hospital under the Republican plan.

Under emergency care, we of course require that you would be able to go to any emergency room. You do not have to go 50 miles away. You do not need prior authorization because we have what we call a prudent layperson standard. If the average person thinks that this is an emergency, then they go to the local emergency room and they do not need prior authorization; otherwise, it is not an emergency.

In the Republican plan, again, they have so many loopholes. They say that severe pain is not a standard that a reasonable person could apply and go into the emergency room. So if you think you are in severe pain, and that is the reason you go to the emergency room without prior authorization, it turns out you did not have a problem, then they are not going to pay for it, because your basis was going there with severe pain. I can go on, and I do not want to because I think we can bring some of these things out.

Essentially, there is no progress on the issue at all with the Republican plan. It is not a meaningful way to move forward at all on the issue of managed care reform.

Mr. Chairman, I yield to the gentlewoman from Michigan who, again, has been outstanding on this issue and has been getting a lot of input back from her constituents on the need for this Democratic proposal.

Ms. STABENOW. Mr. Chairman, I thank my friend, the gentleman from New Jersey, and to echo what all of my colleagues have said for all of his hard work, he has been a wonderful leader and he has been here many, many late nights. We are all here late tonight, because we care very much about this issue, and he has been here many, many late nights.

Today, we are here as Democrats from New Jersey to Pennsylvania to Texas to Michigan. I do want to start, though, by saying that, most importantly, we are here as Americans who want to allow every one of our families to be able to participate in what is the best health care system in the world.

How ironic that we have the best health care, and, yet, people cannot receive the best health care because of the ways systems have been set up.

We do not want to be here talking about Democrats versus Republicans. We want to ask them to join us. Unfortunately, it has become an issue separating us because of whose interests we are reaching out to protect, American people wanting health care or those who benefit, the insurance companies who are benefiting by the current status quo.

I want to share with my colleagues this evening just one letter of many that I have received from families in Michigan. This speaks very much to the issue of emergency room care as well as a number of other issues that have been raised this evening. This is from a constituent of mine.

''My husband was working on a job when he had a chain saw kick back and cut into his lower left leg. He was rushed to the nearest hospital where he was immediately put into a trauma unit where the doctors began assessing the damage and preparing a medical plan of action. The chain saw stalled in his tibia bone after severing all the muscles, veins, and nerves in his lower leg.

''The hospital's plan was to take him to an operating room, with an orthopedic surgeon, vascular surgeon and a neurology surgeon. Per my health insurance card's instructions, the hospital personnel contacted my HMO who insisted that my husband be transferred to another hospital. The physician in charge did not agree, claiming the accident was too severe to move him. The HMO clerical claimed that, if treated, the HMO would not pay the bill.

''The ambulance drivers were instructed to leave my husband on a gurney by the door at the second hospital, where he remained for 9 hours without any pain medication. He was not even given any ice to put on the wound. We finally saw the emergency room physician after 9 hours and after my husband tore a phone out of the wall and threw it on the floor'' due to his severe pain.

''Eventually, my husband was given nine loose stitches in his leg, put in a cast, and sent home after laying in his filthy, wood-chip covered clothing for 28 hours'' in the emergency room. ''He never received any surgery'', which was recommended, and ''is now in constant pain from permanent nerve and vascular damage, which were both medically repairable during the first 24 hours following the accident.

''We have found a physician who is willing to attempt some orthopedic repair. This has taken all of our savings because he is not in the 'network'' of the HMO.

''This corporation has been allowed to hold my family prisoner for 12 months. The lack of medical care they have provided has cost my husband a normal life. We have since lost our business and are trying to sustain our family of four on one income.''

This is a situation that should never happen in the United States of America. There is absolutely no reason why this gentleman was not treated immediately in the emergency room with the care that he needed which was recommended by the doctor in charge.

Our bill, the Patients' Bill of Rights would reinstate that critical relationship between the physician and the patient. Instead, the Republican leadership bill would do little to protect the family that I just talked about.

As my colleague, the gentleman from New Jersey, talked about earlier, the whole issue of referring to severe pain as well is excluded from their bill in terms of defining when you can receive care in an emergency room. In fact, what we are talking about is the medically sound advice of a doctor, such as the doctors in the emergency room that I just talked about, being able to treat someone without having to look to an HMO that is not in the best interest or used in the best interest of the patients involved.

Let me just say, in conclusion tonight, that we are fighting for that woman, that family that was in that emergency room, and all of the other families across America that want very much, that expect in this country to have the quality health care that they need for themselves and their families.

Ms. MILLENDER-McDONALD. Mr. Speaker, I would like to join my colleagues tonight in explaining to the American people what the Republican leadership is doing—as opposed to claiming to be doing—to address a disturbing trend in the nation's health care system.

We have heard story after story of how doctors have recommended certain medical procedures and health insurance companies have claimed that it is not necessary and not covered. We have heard over and over again about women who have not been allowed to have their gynecologist serve as their primary doctor and instead, have been forced to waste time and money visiting their primary doctor each time they need to see their gynecologist. We know the same treatment occurs when patients seek specialists and are instead dragged through a painfully slow process of going to their primary care physician every time they need their specialist. This has resulted in delayed treatment and even in the loss of lives.

One issue on which I have worked extensively is creating more opportunities for children and those in need to receive bone marrow transplants. Although most health insurance companies claim that they cover bone marrow transplants, in reality, few cover the complete cost involved in saving a child's life. Every year in this country, 30,000 people are diagnosed with diseases such as Leukemia and Sickle Cell Anemia that can be successfully treated with a bone marrow transplant. The marrow transplant procedure is no longer considered an experimental procedure.

It has been peer-reviewed in numerous professional medical journals, which is the basis for determining ''medically appropriate'' care that will be covered by insurance plans. Beyond meeting this standard, bone marrow

transplant searches and procurement from donors must be covered as well in order to truly save lives.

Bone marrow transplants are just one example of a clearly life-saving and medically appropriate and necessary procedure that needs to be covered by health insurance companies.

The Republican bill leaves medical decisions in the hands of insurance company accountants and not in the hands of those who know best: the doctor and patient.

The Republican bill does not ensure access to specialty care; does not prohibit HMOs from offering bonuses to doctors for denying necessary care; does not prohibit drive-through mastectomies; and perhaps, worst of all, the Republican bill does not hold the health insurance plans accountable when abusive practices kill or severely injure patients.

Despite what those who would rather squander extra dollars for the health industry say, these protections would not result in a significant increase in costs. A recent congressional study concluded that the right to sue, which is in the Democratic Patients' Bill of Rights bill, would result in only an extra $2 a month per employee.

These are just some of the 16 protections that are missing from this Republican fig leaf of a bill that are included in the Democratic Patients' Bill of Rights bill. The Republican bill flies in the face of those lives who have been lost or severely impaired by an incomplete, unfair and sometimes ruthless HMO system. This legislation is seriously flawed not only because it is extremely partisan and has completely circumvented the legislative process, but also because it does little to resolve some of the most daunting problems facing Americans today.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of my Special Order.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

ISSUES OF HIGH NATIONAL IMPORTANCE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentleman from Georgia (Mr. BARR) is recognized until 12 midnight as the designee of the majority leader.

Mr. BARR of Georgia. Mr. Speaker, I would like to spend a few moments this evening engaging in what we used to as children called paint by numbers. The Speaker may recall those paint by numbers where, when you open a box of that paint by number, you are basically presented with what appears to be an incoherent picture, white with some black lines on it and some numbers. Only as you fill in the numbers so designated at some point does the full impact of that picture really become clear.

The paint by number picture about which I speak tonight has to do with fundamental constitutional powers such as separation of powers and other very clear concepts and philosophy and powers designated explicitly or implicitly in our Constitution, in other words, very, very grave issues of high national importance.

The picture being painted by the administration is not one that is being painted directly through the normal time honored and constitutionally sound process of proposing legislation, fully debating that legislation, holding hearings on that legislation, making changes to that legislation, further debating that legislation, allowing Members and, indirectly, the American people to vote on that proposed legislation, reflecting their will, their desires, their needs, that is the will, the desire, and the needs of the American people, and then having a similar process of public vetting, as it were, take place in the Senate.

Then and only then would the President as the Chief Executive Officer of this country either approve or veto that legislation at which time, if it is signed reflecting, one presumes, the desires of the Chief Executive would it become the law of the land.

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It would be, thereafter, subject to whatever scrutiny those who object to it, who might object to it, would raise through our court system.

That is how the system ought to operate. And whether each one of us agrees or disagrees with any particular laws so passed and so signed by the President, at least we have had the opportunity and the American people have had the opportunity through their representatives in this representative democracy to have input, to have an impact, and to understand what it is that is being proposed to ensure to the greatest extent possible that it reflects their views, their needs and their desires. That is the way it ought to be. That is the way normally it is.

Over the course of our Nation's history, we have had dozens of presidents. By and large, each one of them has respected that process. They understand that process, and they abide by that process, because they know it is essential to the fabric and the continuing of this great country.

Unfortunately, Mr. Speaker, what we have currently is something quite different. We have an administration that is attempting to govern by executive order and rules and regulations; attempting to come in through the back door, as it were, when the front door has either not yet been opened or deliberately closed shut by the people's representatives in this great body.

When you see these numbers being filled in, Executive Order 13083, for example, it does become frighteningly clear what is happening in America through essentially a subversion of the process of governing laid out in our Constitution. I would like to mention briefly, Mr. Speaker, just a few examples of this process, or lack of process, this evening.

Let us start with the big picture. Federalism, that concept embodied in our Constitution and honed to a fine art through decades upon decades of activities here in this body and our sister body across the Capitol and at the other end of Pennsylvania Avenue and, indeed, as well through the court system.

On May 14, 1998, perhaps just by coincidence while he was outside the continental United States of America in England, President Clinton signed Executive Order 13083, on May 14, 1998. This is an Executive Order entitled simply ''Federalism,'' similar in its title and in its prefatory language to an Executive Order issued 11 years ago, in 1987, by President Reagan.

There the similarity ends. The Executive Order on Federalism issued in 1987 by President Reagan was a blueprint that was consistent in every respect with the concepts of Federalism embodied in and contemplated by the founders of our Constitution, our Founding Fathers.

It basically served over the course of the last 11 years to set forth a policy of the Executive Branch of government that unless there was a specific power on which any and all Federal agencies or departments could base prospective action involving powers normally granted to, subsumed by or exercised by state or local governments, then, in the absence of such clear express authority, President Reagan's Executive Order directed that the agency or the department contemplating such action should not and would not move forward with it. In other words, it was a limiting Executive Order.

What we have, Mr. Speaker, in Executive Order 13083, signed on May 14, 1998, by President Clinton, is an Executive Order that, while it purports to embody concepts of Federalism similar to that put forth by President Reagan, it does exactly the opposite.

Executive Order 13083 is a blueprint providing justification for any agency or department of the Executive Branch to involve itself in any activity, particularly those normally subsumed by or exercised by state or local governments, so long as that proposed activity falls into one of nine categories of activities that are so broad as to encompass virtually any activity any administration would want to involve itself in.

For example, number one, when the matter to be addressed by Federal action occurs interstate; two, when the source of the matter to be addressed occurs in a state different from the state or states where a significant amount of the harm occurs; three, when there is a need for uniform national standards; four, when decentralization increases the costs of government; five, when states have not adequately protected individual rights and liberties; six, when states would be